Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: (877) 208-7428 **Phone:** (800) 745-7318

Progesterone Agents Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name ______________________________ First name ___________________________ MI __________

MassHealth member ID # __________________ Date of birth _______________________________________

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Medication requested

☐ Crinone 4% (progesterone gel)
☐ Crinone 8% (progesterone gel)
☐ hydroxyprogesterone caproate injection
☐ Makena (hydroxyprogesterone caproate injection)
  ☐ Intramuscular (IM) ☐ Subcutaneous (SC)

☐ Other* ____________________________
**If request is for a non-preferred brand name or generic product, please attach supporting documentation (e.g., copies of medical records and/or office notes regarding adverse reaction or inadequate response to the preferred product).*

Frequency and duration of therapy requested ____

Indication (Check all that apply.)

☐ Amenorrhea
  ☐ Primary ☐ Secondary
☐ History of spontaneous preterm delivery and/or premature rupture of membranes
☐ Other (Please indicate.) ____

Please note: MassHealth does not pay for any drug when used to promote male or female fertility as described in 130 CMR 406.413(B) “Limitations on Coverage of Drugs-Drug Exclusion.” For additional information go to: www.mass.gov/regulations/130-CMR-406000-pharmacy-services.

Please indicate whether the request is for pharmacy or in-office billing. ☐ Pharmacy billing ☐ In-office billing

Section I. Please complete for hydroxyprogesterone caproate injection (generic Makena) requests.

1. Please indicate the current gestational week. ____
2. Is the member currently pregnant with a singleton gestation? ☐ Yes ☐ No. Please explain.
   ____
3. Was the prior spontaneous preterm delivery a singleton gestation? ☐ Yes ☐ No. Please explain.
   ____
4. Please indicate the gestational week(s) for the member's prior preterm delivery. ______________________

Section II. Please complete for Crinone 4% and 8% gel requests.

1. Please provide clinical rationale for the use of the requested medication instead of oral progesterone (micronized), medroxyprogesterone, or norethindrone. ____
   ____
2. For Crinone 8% gel requests, has the member had a trial with Crinone 4% gel?
   ☐ Yes. Please list the dates/duration of use and outcomes below.
   Dates/duration ________________________ Outcome ____
   ☐ No. Please explain. ____

Section III. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

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Section IV. Please include any other pertinent information (if needed).

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Prescriber information

Last name* ______________________ First name* ______________________ MI __________

NPI* ______________________ Individual MH Provider ID ______________________

DEA No. ______________________ Office Contact Name ______________________

Address ______________________ City ______________ State ________ Zip __________

E-mail address ____

Telephone No.* ______________________ Fax No.* ______________________

** Required*

Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required ____

Printed name of prescribing provider ______________________ Date ______________________